Exhibit 2

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DARRYL LEE CHERRY, Plaintiff,	:	
v.	:	Civil Action No. 04-292 (Erie)
UNITED STATES of AMERICA, et al., Defendants.	:	

DECLARATION OF DENNIS OLSON, M. D.

1. I, Dennis Olson, M.D., do hereby declare that I am the Clinical Director at the Federal Correctional Institution (FCI), McKean County, Bradford, Pennsylvania. I have been employed in this capacity since approximately June 4, 1989.

2. The medical records of the inmates incarcerated at FCI McKean are maintained in the Health Services Unit (HSU) at FCI McKean in the ordinary course of business. As the Clinical Director at FCI McKean, I have access to the medical records of all the inmates incarcerated at FCI McKean, that are maintained in the ordinary course of business, including the medical record of inmate Darryl Lee Cherry, Register Number 07928-078, the Plaintiff in the above-captioned civil action.

3. I have reviewed inmate Cherry's prison medical records. The following is a summary of the medical attention he received at FCI McKean that are related to the medical treatment he received between June 30, 2000, and June 17, 2005, at FCI McKean.

a. On June 30, 2000, a medical intake screening was conducted at FCI McKean. Cherry reported a history of intravenous drug abuse for 15 years. He reported he had not taken drugs for 15 years. He reported a history of venous insufficiency with recurrent leg ulcers, with the left leg worse than the right leg. He reported he wore elastic hose. He denied suicidal ideations. His medications were reviewed. It was noted his last tuberculosis test (PPD) was on May 31, 1999. He was scheduled for a PPD test. He was placed on the General Medical Clinic list for venous insufficiency. See, Medical Record of Darryl Lee Cherry, at p. 116,

attached hereto and labeled Document "a."

b. On July 5, 2000, Cherry came to the Health Services Unit (HSU) for a dressing change for the venous ulcer on his left ankle. He also had an ulcer on his right ankle, but the dressing was in tact. The ulcerated area was egg-sized with an open lesion on the medial aspect of his left ankle. A small amount of yellow discharge was noted on the dressing. He was assessed with venous insufficiency with leg ulcer. The wound was cleansed with Betadine and anti-bacterial ointment was applied. The wound was covered and dressed in gauze. He was prescribed Ibuprofen, and he was educated to return to sick call in the morning for a dressing change and to have his right ankle checked. He was told to take the medication as directed and to raise his legs as often as possible. He was placed on medical convalescence through July 19, 2000. Id., at pp. 116-117, 155.

c. On July 6, 2000, Cherry returned for a dressing change. Edema was noted on his lower extremity. The ulcer was observed on his left ankle at the medial malleolus. Serous drainage was observed with no signs of infection. On his right lower extremity, a small skin opening at the distal tibia medial aspect with white, clear serous drainage continuously seeping out was observed, with no signs of infection. He was assessed with venous insufficiency. The areas were cleansed with sterile water. Silvadene cream was applied, sterile dressing and an ace wrap were applied. He was given elastic stretching, Silvadene cream, and dressing supplies. He was educated to keep the area clean, and instructed to follow up the following day. Id., at p. 117.

d. On July 12, 2000, Cherry reported scars from knife wounds. He had four leg ulcers on his right ankle, three ulcers on his left ankle, and one ulcer on his right foot with edema caused by venous insufficiency. It was noted he was a 47 year old male, 73 inches tall, and weighing 246 pounds. He had no known drug allergies. He had a 20 year history of intravenous drug abuse and no history of tuberculosis. His health issues were identified as venous insufficiency for 12 years with leg ulcers. It was noted that when he was 14 years old, he had a bone graft to his left and right ankle. He was referred for Hepatitis B and C tests, a liver profile, a urine analysis, and an optometry consultation. He was placed on convalescence status due to venous insufficiency. It was indicated he would not be cleared to work in food services, Health Services, or the barber shop until the lab work was returned. Id., at pp. 157-58. After the physical examination, He was given a tetanus shot. He was given one container of Silvadene, and the Hepatitis laboratory tests were ordered. Id., at pp. 114, 155. Also, on July 12, 2000, he was placed in the chronic care clinic for chronic leg ulcers. Id.

e. On July 18, 2000, an unna boot was ordered. Id.

f. On July 18, 2000, he was seen for the ulcer and wounds from the ulcer. Ulcers at the medial aspect of his lower leg and right ankle were observed with serous exudate. An ulcer was observed at his left ankle close to the heel area. He was assessed with leg ulcers and venous insufficiency. The wounds were cleaned with sterile water. Silvadene was applied. He was given Silvadene cream. He was educated to keep the area clean. Id., at pp. 114, 155.

g. On July 20, 2000, a Hepatitis B and C profile and a Liver Profile were conducted. The results were received on July 26, 2000, indicating he tested positive for the Hepatitis C antibody. Also, the lipid profile indicated the following results outside of the applicable reference ranges: (1) Total Protein 8.6 (reference range 6.3 - 8.3); (2) AST 48 (reference range 10 - 37); (3) ALT 42 (reference range 8 - 40); (4) Total Bilirubin 1.2 (reference range 0.1 - 1.1); (5) Direct Bilirubin 0.4 (reference range 0.0 - 0.3); (6) GGT 110 (reference range 10 - 45). He was non-reactive to the Hepatitis A and B antibodies. He was referred to the clinic for follow up. Id., at p. 138.

h. On July 20, 2000, he had a Rapid Plasma Reagin (RPR) test. On July 25, 2000, the results of the RPR test were received at FCI McKean, indicating he was non-reactive. Id., at p. 139.

i. On July 24, 2000, Plaintiff reported to the HSU for a dressing change. Multi-stasis ulcers were observed over the right lower extremity at the ankle and medial foot. Some oozing of sero sanguinous fluid without a foul odor was observed. Edema of the lower extremity was noted. Plaintiff was assessed with stasis ulcer, history of lower extremity and intravenous drug abuse. The wound was cleaned with soap and water. Silvadene was applied. It was dressed with sterile dressing and covered with TED stretching. Plaintiff was told to return the following day for the application of the unna flex boot. Id., at p. 115.

j. On July 25, 2000, his leg was checked. Leg ulcers were observed on the lower extremities with edema and no signs of infection. He was assessed with chronic leg ulcers. The ulcerated area was cleaned with soap and water. Silvadene cream and sterile dressing was applied. He was given dressing supplies. He was educated to elevate his legs. It was noted the unna boot was in the warehouse, and would be picked up the following day. Id., at pp. 115.

k. On July 26, 2000, he was placed on the general medicine clinic list, and he was notified he tested positive for the HCV anti-body. Id., at pp. 112, 171. Also, on July 26, 2000, he reported to the HSU because he was bleeding through the dressing and because of his history of peripheral vascular disease (PVD) secondary to intravenous drug abuse, at his right medial ankle. Multiple superficial ulcerations were noted at his right medial ankle with exudate. There

was evidence of recent bleeding. He was assessed with PVD, venous insufficiency and stasis ulcers. Dressing was applied. Plaintiff was told to follow-up for dressing changes. Id., at p. 112.

l. On July 28, 2000, he was sent to the HSU after it was observed he was bleeding through his dressing. Multiple superficial ulcers on his right medial ankle were observed with a small amount of yellow drainage. He was not bleeding at that time. He was assessed with venous insufficiency and leg ulcers. The unna boot was applied, followed by gauze wrap and an ace bandage. He was placed on the medical call out list for August 4, 2000 for a dressing change. He was placed on medical convalescence through August 3, 2000. Id., at pp. 112-113.

m. On August 3, 2000, he was seen in the General Medical Chronic Care Clinic for HCV. He reported he felt good. A leg ulcer was observed on his lower right leg. The unna boot was removed, and a new boot was re-applied. Plaintiff reported he smoked a half a pack of cigarettes each day. He had a poor appetite, and stated he ate once a day. He reported he did no exercising. It was noted he was taking Motrin as needed for leg pain. He stated he experienced difficulty walking due to venous insufficiency and leg ulcers. His vital signs were taken. His lungs were clear to auscultation. His heart indicated regular rales and rhythm. His abdomen was soft and non-tender with no organomegaly or masses. His peripheral pulses were in tact. Superficial venous ulcers were observed at the medial aspect of his right ankle. He was assessed with chronic HCV and venous insufficiency. He was told to return to the clinic in three months. He was educated regarding the disease complications, progression and prognosis, diet, weight loss, smoking, exercise and medication. Id., at pp. 110-111.

n. On August 8, 2000, he requested a refill of Silvadene and an extension of medical convalescence. A physical examination was deferred. He was assessed with venous insufficiency. His convalescent status was continued until August 15, 2000. He was given Silvadene ointment, and he was instructed to keep the wound area clean and dry. Id., at pp. 108, 155.

o. On August 11, 2000, he reported to the HSU for a dressing change for his left ankle. He was alert, and seemed to be doing better. No exudate or open ulcers were seen. He was assessed with venous insufficiency. The wound was cleansed, and Silvadene was applied. The dressing was changed and a new unna boot was applied. The area was covered with elastic six-inch wrap. He was prescribed Tolnaftate cream. He was told to keep the affected area clean and dry and follow up at sick call. Id., at pp. 108, 155.

p. On August 18, 2000, he returned for a dressing change. On observation, his right medial ankle was slightly erythematous. Small scabs were observed over areas at

the base of his great toe and the dorsal aspect of his foot. No open areas were noted and the edema had decreased. He was assessed with venous insufficiency with resolving leg ulcers. His leg was cleansed and Silvadene was applied with a new unna boot. A gauze wrap and an ace wrap were applied. He was placed on call out for August 25, 2000 for a dressing change. Id., at p. 109.

q. On August 25, 2000, he reported to have his leg checked. He also requested a cholesterol check. On observation, his right medial ankle was clear. No open areas were noted. No edema was evident. Peripheral pulses were in tact. Small open areas were noted on the medial aspect of his left ankle. Slight erythema and edema were noted with decreased peripheral pulses. He was assessed with venous insufficiency with stasis ulcer of the left ankle. The Unna boot was applied to the left leg. He was told to keep the area dry, and to raise his left leg. He was placed on the call out list for the following week for a re-check of his leg. A lipid profile was ordered. He was prescribed Motrin. Id., at pp. 109, 155.

r. On September 8, 2000, he reported to HSU to have his left leg checked and to have the unna boot applied. Non-pitting edema was noted of his left lower leg, ankle and foot. Small open areas were noted on the medial aspect of his left ankle. No erythema was noted. No drainage was observed. His pedal pulses were diminished. He was assessed with stasis ulcer of the left ankle and venous insufficiency. Silvadene cream was applied to the medial aspect of the left ankle followed by the unna boot, gauze wrap and an ace wrap. He was placed on the medical call out for September 16, 2000, for a dressing change. He was instructed to keep the dressing dry, and to raise his left leg. Id., at p. 106. Also on September 8, 2000, a Lipid Profile was conducted. The results were returned to FCI McKean on September 11, 2000, indicating his HDL Cholesterol level of 32 was outside of the applicable reference range of 35 - 80. Id., at p. 137.

s. On September 16, 2000, he returned for a dressing change. A dime-sized stasis ulceration was observed on his right foot. Other ulcers remained dressed. No unna boot material was available for the dressing change. He was assessed with stasis ulcer. The wound was cleansed with hydrogen peroxide. Silvadene was applied with new dressing. Plaintiff was instructed to keep the wound clean and dry. Id., at p. 107.

t. On September 19, 2000, he returned for a dressing change. On observation, a stasis ulcer was observed on the left foot and right ankle. There was no swelling, no edema, no erythema, or signs of inflamation. He was assessed with stasis ulcer. The wounds were cleansed and Silvadene was applied with the new dressing. He was prescribed Silvadene to use as needed and Trental (also known as Pentoxyphylline - a medication used to improve blood flow by decreasing the viscosity of blood). He was educated to keep the area clean and dry, and to take

the medication as directed. Id., at pp. 107, 154-155.

u. On October 13, 2000, he requested a refill of Silvadene cream and supplies. On examination, his left lower leg, ulcers with no drainage due to venous insufficiency were observed. No cellulotic changes were observed. He reported occasional redness and pain. He was assessed with stasis ulcer of the left ankle due to venous insufficiency. He was prescribed Silvadene cream, gauze, and gauze wrap. He was told to follow up in sick call if needed. He was placed on medical restrictions. Id., at pp. 104, 154-155.

v. On November 2, 2000, he was seen in the General Medicine Chronic Care Clinic. He denied abdominal pain or jaundice. He reported he had not quit smoking; his diet was good; and he engaged in limited activity. He reported no side effects from the medications, and he was in compliance with his therapeutic regimen. His vital signs were taken. He was in no acute distress. He was assessed with HCV and venous insufficiency. He was prescribed Trental. He was scheduled to return to the clinic in three months. He was educated regarding the nature of the disease, complications from the disease and treatment alternatives. He was also educated regarding smoking. Id., at pp. 102-03, 154-155.

w. On November 21, 2000, he reported for application of the unna boot. On observation of his left leg, an open ulcer was observed at his medial malleolar aspect with serous exudate and edema. No signs of infection were observed. He was assessed with stasis ulcer of the left leg and venous insufficiency. The wound area was cleaned with sterile normal saline solution. Silvadene cream was applied. A paste bandage was applied with zinc oxide and wrapped on his left leg, ankle and foot, followed by three inches of conforming gauze and a four inch ace wrap. He was educated to elevate his left leg and told to follow up as needed. Id., at p. 100.

x. On November 30, 2000, he returned for application of the unna boot. A healing ulcer was observed at his left medial ankle area. No exudate was noted. Swelling and edema were observed. He was assessed with venous insufficiency and healing ulcer of the left ankle. Silvadene cream was applied. A paste bandage was applied followed by conforming gauze and an Ace wrap. He was educated to elevate his left leg. Id., at p. 100.

y. On December 8, 2000, he reported for a dressing change. He stated he was doing well. A healing small granulating ulceration was observed at the medial aspect of his left ankle with pitting edema, scarring, decreased hair growth and increased pigmentation. Poor healing with decreased pulses of the left lower extremity was observed. He was assessed with venous insufficiency, stasis ulcer of the left ankle. A paste bandage was applied with zinc oxide and covered. He was

educated to keep it on for one week, and to follow up at sick call in one week. Id., at p. 101.

z. On January 10, 2001, he returned for dressing supplies and requested medication refills. A physical examination was deferred. He was assessed with stasis ulcer of the left ankle. Silvadene was prescribed. Id., at pp. 101, 154.

aa. On February 1, 2001, he reported to the General Medicine Chronic Care Clinic. He reported he was losing hair on his scalp and face. He had not quit smoking; his diet was good, and he was engaging in limited exercise. His vital signs were taken. He was in no apparent distress. Patchy areas of decreased hair was observed on his scalp and beard. His lungs were clear, regular rales and rhythm were observed. His abdomen was non-tender. He displayed no symptomatology of Hepatitis C. He was assessed with HCV, alopecia rule out tinea, and venous insufficiency. He was prescribed antifungal cream, hydrocortisone cream and Trental. 4x4 inch and 2x2 inch gauze pads and non-stick pads were given to him. Diagnostic studies were ordered. He was told to return to the clinic in three months. He was educated regarding diet, skin care and medication use. Id., at pp. 98-99, 153, 156.

bb. On February 15, 2001, a liver profile was conducted. On February 20, 2001, the results were received at FCI McKean with the following levels outside of the applicable reference ranges: (1) Total Protein 8.4 (reference range 6.3 - 8.3); (2) AST 43 (reference range 10 - 37); (3) Total Bilirubin 1.5 (reference range 0.1 - 1.1); (4) Direct Bilirubin 0.4 (reference range 0.0 - 0.3); and GGT 102 (reference range 10 - 45). Id., at p. 135.

cc. On or about February 17, 2001, a blood specimen was tested at an outside hospital to determine the rate of coagulation. The result of this test indicated Plaintiff was in the normal range for coagulation. Id., at p. 136.

dd. On March 8, 2001, he complained of lesions on his left lower extremity. On observation he had brawny edema and pitting edema, and healing crusted lesions of the left ankle. He was assessed with venous insufficiency. A paste bandage was applied and covered with flex gauze and an ace bandage. He was educated to elevate his legs. HCTZ (also known as hydrochlorothiazide, a diuretic used to treat high blood pressure) was started. Id., at pp. 96, 153.

ee. On April 17, 2001, he reported bleeding from his left leg. On examination, gauze pads Plaintiff had applied earlier were observed over the wound of the left ankle area. A small amount of dried blood was observed. No actual bleeding was observed at that time. A pinhole-sized opening was observed in the dilated vein. He was assessed with varicose veins with bleeding. His dressing was changed.

Gauze, Kling, and elastic wrap were applied. He was educated regarding wound care and elevation of the wound. He was told to report to sick call in the morning. Id., at p. 96.

ff. On May 3, 2001, he was seen in the General Medicine Chronic Care Clinic. He had no complaints of abdominal pain or jaundice. He reported he was losing hair on his scalp and face. He had not quit smoking. His diet was good, and he was engaging in limited activity. His vital signs were taken. He was assessed with positive HCV, venous insufficiency, greater on right side, and rule out tinea. He was prescribed Mycelex cream, Betamethasone Valisone cream (a corticosteroid used for the topical treatment of skin irritations), Ibuprofen, Trental and HCTZ. He was told to return to the clinic in three months. He was educated regarding treatment alternatives, diet, weight loss and exercise. Id., at pp. 94-95, 153.

gg. Later on May 3, 2001, he requested dressing supplies and an examination of his legs. Small pinpoint open areas were observed on the medial aspect of his right foot and ankle. A small open area was observed at the back of his left foot. No drainage was noted. He was assessed with chronic venous stasis ulcer of his right ankle and peripheral vascular disease. An unna boot was applied to his right leg lower leg and foot. He was instructed the boot was to remain on for 7-10 days. Silvadene and dry sterile dressing was applied to the left posterior foot. He was told to return as needed for dressing changes or supplies. Id., at p. 92.

hh. On May 6, 2001, an administrative notation was entered indicating a call was received from an officer in the Special Housing Unit (SHU), to verify his need for a unna boot while he was in SHU. The officer was advised he was to wear the unna boot for 7-10 days, and thus, it should remain on unless ordered by a physician to be removed. Id., at p. 92.

ii. On July 11, 2001, he complained of right flank, back and right upper leg pain since the previous Friday. He complained of burning urination. On examination, his lungs were clear to auscultation. His abdomen was soft and non-tender. No organomegaly or masses were observed. Bowel sounds were present. Slight right flank and right lumbosacral pain was observed on palpation. No edema or erythema were observed. He was assessed with possible urinary tract infection vs. lumbosacral strain. A urine analysis was ordered. He was told to return the specimen to the lab in the morning. It was indicated that ensuing treatment would be determined depending upon the results of the urine analysis. He was told to return on July 12, 2001. Id., at p. 93.

jj. On July 12, 2001, the HSU received a call from his housing unit indicating he was experiencing severe pain and needed to be seen. On observation there was tenderness on palpation to the lumbosacral area and right hip with decreased range

of motion. No edema or erythema were observed. He could not do a straight leg raise. It was noted that his urine analysis was within normal limits. He was assessed with lumbosacral strain. He was prescribed Ibuprofen, and he was issued a medical idle through July 12, 2001. He was told to apply warm moist compresses and return as needed. Id., at pp. 93, 153.

kk. On July 16, 2001, he complained of lumbosacral sprain. On examination, he was alert. He was able to do straight leg raises. It was noted he had no history of direct trauma. He had tenderness over the right knee area with no swelling or tenderness in the calf area. He could flex his left knee. He was assessed with lumbar strain of the right side. He was prescribed Ibuprofen. He was told to apply moist heat and use the lower bunk. He was issued a lower bunk pass and a medical idle. He was given a wheelchair. He was instructed to follow up as needed. Id., at pp. 90, 153.

ll. On July 17, 2001, his complaints of lower back pain and R10 radiculopathy were noted. An orthopedic consultation was scheduled and an x-ray was taken of the lumbo-sacral spine. Id., at p. 90.

mm. On July 27, 2001, an administrative notation was made indicating the pharmacy was notified of the need to refill hislast bags of medications. Id., at p. 91.

nn. On July 31, 2001, he was seen by the contract orthopedic surgeon for lower back pain, rule out radiculopathy. He reported he experienced severe right lower leg pain with swelling for approximately two and one half to three weeks. He denied back pain. He reported the symptoms appeared suddenly without injury approximately two weeks prior. He complained of inability to lay on his left side. After a physical examination and a review of x-rays, he was assessed with vascular vs. neurologic complications. It was recommended that vascular studies of his right lower extremity be ordered. It was recommended that an EMG of the right lower extremity be considered. It was also recommended Trental be considered, and analgesics be considered to treat the pain. Id., at p. 160.

oo. On July 31, 2001, an administrative notation was entered indicating he was to remain on convalescence status until August 14, 2001. Trental and encoated aspirin were prescribed, and previously-renewed refills were canceled. He was referred to the Utilizaton Review Committee (URC). Id., at pp. 91, 153.

pp. On August 2, 2001, he was seen in the General Medicine Chronic Care Clinic. He complained of aches and pain from the front of his right thigh to his knee, which increased some with walking. He denied abdominal pain and lower back pain. He did complain of a rash on his face. He had not quit smoking. His diet was good, and it was noted he engaged in limited activity. He complied with his

therapeutic regimen, except for smoking. His lungs were clear, and his heart sounded normal. His abdomen was without organomegaly. No edema was observed on his extremities. His toes were warm to the touch. He was assessed with HCV, rule out peripheral vascular disease (PVD), and rash. Trental and aspirin were continued. He was prescribed HCTZ and Fluocinonide cream. He was told to return to the Clinic in three months. He was educated regarding the nature of the disease, complications of the disease, its progression and prognosis, treatment alternatives, diet, quitting smoking, and exercise. His test results were explained to him. Id., at pp. 88-89, 153.

qq. On August 14, 2001, he requested a medication refill. The physical examination was deferred. He was assessed with right thigh pain, muscular. He was prescribed Ibuprofen, and he was educated regarding taking the medication as directed. Id., at pp. 86, 152. Also on August 14, 2001, a lipid test and a liver test were conducted. On August 15, 2001, the results were returned to FCI McKean showing the following results outside of the applicable reference ranges: (1) Total Protein 8.3 (reference range 6.0 - 8.2); (2) Alkaline Phosphate 139 (reference range 41 - 133); (3) A/G Ratio 0.93 (reference range 1.00 - 2.30); (4) Globulin 4.3 (reference range 2.0 - 3.7); (5) Gamma GT1 145 (8 - 78). The laboratory report indicated he had several other factors which were critical to the assessment of coronary heart disease (CHD) risk, including overweight, blood pressure, smoking and familial history. Id., at p. 134.

rr. On August 21, 2001, an administrative notation was entered indicating his convalescence was extended until September 4, 2001. Id., at p. 86.

ss. On August 24, 2001, an administrative notation was entered indicating his old wheelchair was replaced with a new one. His convalescence status was renewed through August 31, 2001. He was approved to sit in class for education. Id., at p. 86.

tt. On August 26, 2001, it was noted he arrived at the HSU via wheelchair with complaints of lower left leg oozing. Small blistered areas were observed on the lateral aspect of the left foot and anterior ankle. A small pinpoint opened area was observed at the lateral left foot. He was assessed with chronic venous stasis ulcers of the left foot, and peripheral vascular disease (PVD). His foot was re-wrapped with an ace bandage. He was told to return in the morning for an evaluation for a possible unna boot application. Id., at p. 87.

uu. On August 29, 2001, he returned via wheelchair for a dressing change and possible toenail clipping. A small opened area measuring one centimeter around was noted on his left lateral foot. Small scattered blistered areas were observed on his lateral foot. No drainage was noted. He was assessed with chronic venous

stasis of the left foot. A four inch paste bandage was applied to the left lower leg/foot, covered with an ace wrap. Bilateral thickened toenails were clipped. He was educated on walking and exercise to promote circulation, and proper diet to increase healing. Id., at p. 87.

vv. On September 3, 2001, an administrative notation was entered into his medical record indicating he was on a town trip for a doppler study. Id., at p. 87.

ww. An x-ray report dated September 16, 2001, of Plaintiff's lumbar spine was unremarkable. Id., at p. 141.

xx. On September 17, 2001, the report from the bilateral venous doppler was received at FCI McKean. The report indicated normal color flow, cross-sectional collaspsibility and augmentation throughout the vessels of both right and left lower extremities. There were some poor or low flow areas in the calf suggesting previous thrombus or chronic change to the veins in the lower calf area. Incompetence of the deep valves was suggested. Reversal of flow was evident with Valsalva. There was no evidence of deep venous thrombus in the study. Id., at p. 143.

yy. On September 18, 2001, he came to the HSU to get the results of the doppler study. Also he requested Tylenol instead of Motrin. The physical examination was deferred. He was assessed with peripheral venous insufficiency, and he was referred for counseling. His doppler test results were reviewed with him, and Tylenol was prescribed. He was educated to take the medication as directed, and to increase his exercising, especially ambulation. He was instructed to return as needed. Id., at pp. 84, 152.

zz. On September 24, 2001, an administrative notation was entered indicating the results of the doppler study showed no deep vein thrombosis and the evidence suggested previous thrombus or chronic changes. Id., at p. 84.

aaa. On October 16, 2001, he complained of right hip pain, radiating from his thigh to his knee. He walked with a cane and had a limp. He experienced tenderness at his right hip upon palpation. No edema or erythema was observed. Decreased flexion and extension of his back was observed. He was assessed with right hip and thigh pain, rule out degenerative joint disease (DJD). X-rays were ordered for his right hip. He was issued a medical idle through October 17, 2001. He was educated to use warm compresses and to return as needed. Id., at p. 85.

bbb. On November 1, 2001, he was seen in the General Medicine Chronic Care Clinic. He denied abdominal pain and jaundice. He indicated he had not quit smoking, and he was doing some walking. His vital signs were checked. He was in no

acute distress. He jumped up on the examination table without a problem. He was assessed with HCV, peripheral venous insufficiency and lower back pain. He was prescribed Ibuprofen, Pentoxifylline, Hydrochlorothiazide, and encoated aspirin. He was instructed to return to the clinic in three months. He was educated regarding the nature of the disease, treatment alternatives, diet, and smoking. Id., at pp. 82-83, 152.

ccc. On December 13, 2001, he was seen by the contract Optometrist, because his left eye was weak. After an examination, he was assessed with compound hyperopic astigmatism (CHA) and presbyopia (an age-associated progressive loss of the focusing power of the lens resulting in difficulty seeing objects close-up). It was recommended that prescription lenses be ordered. Id., at p. 161.

ddd. On December 20, 2001, he complained of a sore throat and diarrhea for two days. He reported he had not eaten since the previous day. He stated he felt too sick to work. On examination, he was in no apparent distress. His eyes and ears were clear. His nasal membranes were moist and pink. There was no erythema or edema. His neck was supple without adenopathy (swollen lymph nodes). His chest was clear. His temperature was 96.9. He was assessed with viral syndrome and diarrhea. He was prescribed antihistamines, Tylenol, and Bismuth Subsal (Pepto Bismol). An idle slip was authorized excusing him from work for two days. He was educated regarding hygiene, and he was instructed to return as needed. Id., at pp. 80, 152.

eee. On January 1, 2002, he complained of bleeding on top of his left foot. He stated a vessel broke open. He denied pain. He was in no apparent distress. He had dressing and an ace bandage wrapped around his left foot and ankle. It was noted he also had tape around his left ankle which was constricting circulation to his foot. He stated he did this to stop the bleeding. On his left foot, small pinpoint openings on top of his foot were observed. His foot was cold to the touch, and purple. Pitting edema was observed on his left lower leg above the area where the tape was used. His pulse was slow. No bleeding was observed. He was assessed with varicose vein with bleeding and decreased circulation due to venous insufficiency and tight dressing. He was educated not to use any constricting dressing. The area was cleansed, and Silvadene was applied. Dressing and gauze wrap were applied. He was told to follow up on January 2, 2001. Id., at p. 81.

fff. On January 3, 2002, he complained of dry skin and edema in legs. He stated he was advised he was to be measured for T.E.D. stockings (also known as T.E.D. anti-embolism stockings, they are designed to speed blood flow by providing graduated compression with the most compression at the ankle and gradually diminishing pressure up the calf. They are designed to discourage thrombosis formations for recuperating patients). He was in no apparent distress. His

bilateral extremities were extremely dry, and his skin was scaly. He was assessed with dry skin and stasis edema of the lower extremities. He was given moisturizing cream, thigh-length TED stockings. He was educated regarding hygiene. He was told to return as needed. Id., at pp. 81, 152.

ggg. On January 8, 2002, he returned to have his wound on the top of his left foot re-checked. He stated his belief the wound was a breakdown because of bad circulation, and he indicated the area broke down once a year. An open lesion with a small amount of blood on the dressing on the dorsal aspect of his left foot that was extremely macerated with dry blood were observed. He was assessed with bleeding varicosity. Silvadene was applied. The wound was wrapped with Telfa (a thin layer of absorbent cotton fibers, enclosed in a sleeve of polyethylene terephthalate that is perforated in a regular pattern and sealed along two edges) and Kerlex gauze pads. An ace bandage was applied. He was issued a four-day medical idle. An idle slip directing complete bed rest with a waiver for bathroom and meals only was issued. Id., at p. 78.

hhh. On February 1, 2002, he complained of a rash between his toes, which burned and itched. He also complained of dry itchy skin on both legs. He was in no apparent distress. Maceration with erythema inter-digital bilaterally was observed. Dry flaking skin was observed bilaterally on his lower extremities. He was prescribed Mycelex ointment and A&D ointment. He was told to return as needed. Id., at p. 78.

iii. On February 4, 2002, he reported to the General Medicine Chronic Care Clinic. He denied abdominal pain and jaundice. He had not quit smoking. His diet was reportedly okay. He reported he walked for activity. He reported some side effects from his medications. His vital signs were taken. He was assessed with HCV and peripheral venous insufficiency. He was prescribed Trental, HCTZ, encoated aspirin, Naproxen, and Tolnaftate cream. Motrin was discontinued. He was told to return to the clinic in three months. He was educated regarding the nature of the disease, treatment alternatives, diet, weight loss and exercise. He was issued a soft shoe pass. Id., at pp. 76-77, 152.

jjj. On February 6, 2002, an administrative notation was entered into his records indicating he refused to have his toenails clipped. He was told to return to sick call as needed. Id., at p. 74.

kkk. On February 25, 2002, a liver test was conducted. On February 28, 2002, the results were returned to FCI McKean with the following results outside of the applicable reference ranges: (1) Total Protein 8.7 (reference range (6.0 - 8.2); (2) AST (SGOT) 1.40 (reference range 11 - 55); (3) Total Bilirubin1 1.40 (reference range 0.20 - 1.30); (4) A/G Ratio 0.93 (reference range 1.00 - 2.30); (5) Globulin

4.5 (reference range 2.0 - 3.7); Gamma GT1 151 (reference range 8 - 78). Id., at p. 133.

lll. On May 6, 2002, he reported to the General Medicine Chronic Care Clinic. He reported he felt swollen for a 24 hours. He denied abdominal pain. He stated he smoked about one half of a pack of cigarettes each day, and really wanted to stop smoking. He reported he watched his diet and worked out. He denied side effects from the medications he took. He appeared well, and his physical examination was unremarkable, except for stasis changes of his let lower leg, and nail fungus of his toe nails. He was diagnosed with Hepatitis C, venous stasis of the left leg, smoker with desire to stop. There was no evidence the Hepatitis C had progressed or was causing complications. He was prescribed encoated aspirin, Pentoxifylline, Hydrochlorothiazide, and Tolnaftate. He was prescribed Bupropion (an antidepressant), which had to be taken at pill line. He was instructed to return to the clinic in three months. He was instructed that in order to quit smoking, he was to take Bupropion, one tablet twice daily for five days, then on May 11, 2002, he should take two tablets twice daily in the morning and afternoon pill line for one week. Also, he had to pick a smoking stop date. He was instructed to talk to people around him to achieve compliance. He was educated regarding the nature of his disease and disease complications, progression and prognosis. Id., at pp. 72-73, 151-152.

mmm. On May 11, 2002, he complained of feeling dizzy and funny from taking medication for smoking cessation. He stated he did not want the medications (Bupropion) anymore. He felt he could quit smoking without it. On observation, he was in no apparent distress. He was assessed with drug sensitivity. He was told to sign the refusal form. The consequences of discontinuing the medication were explained. He was told to return as needed. Id., at pp. 70, 152.

nnn. On May 20, 2002, a liver test, a Sodium I test, a Potassium test and a Chloride 1 test were conducted. The results were returned to FCI McKean on May 22, 2002 with the following results outside of the applicable reference ranges: (1) Total Protein 8.4 (reference range 6.0 - 8.2); (2) AST (SGOT) 68 (reference range 11 - 55); (3) A/G Ratio 0.87 (reference range 1.00 - 2.30); (4) Globulin 4.5 (reference range 2.0 - 3.7); (5) Gamma GT1 153 (reference range 8 - 78). Id., at p. 132.

ooo. On June 4, 2002, he reported he was told that 10 years prior, he had a heart murmur. His blood pressure was 110 over 70. His pulse was 72, his lungs were clear. His heart beat with regular rate and rhythm with no murmur. He was assessed with history of murmur, minor now. No special changes in his dental work were medically necessary. Id., at p. 70.

ppp. Later on June 4, 2002, he complained of stasis and varicose veins bilaterally of the

left medical malleolus , usually treated with Silvadene and elastic tape. On observation stasis changes were observed medially on his left ankle, with some crusting and some fresh sera. He was assessed with stasis left medial ulcer. He was prescribed Silvadene. Gauze packs and elastic tape were issued to him. He was told to return the following week for a re-check. He was educated to elevate his leg and to keep it clean. Id., at pp. 66, 151.

qqq. On August 6, 2002, he reported to the General Medicine Chronic Care Clinic. He complained of toenail fungus (long and thick toenails) and pain in his right leg, similar to the episode eight months prior. He wanted his soft shoe pass renewed. He stated he smoked approximately three cigarettes each day. He was careful with his diet, and he was riding the exercise bike. He reported no side effects from the medications he was taking. His vital signs were taken. He was diagnosed with Hepatitis C, peripheral venous insufficiency, and peripheral venous radiculopathy of the right leg. He was prescribed Hydrochlorothiazide, encoated aspirin, Pentoxifylline, and Tolnaftate. He was educated about the nature of the disease, the disease complications, disease progression and prognosis and treatment alternatives. Id., at pp. 68-69, 151.

rrr. On August 19, 2002, a liver test, a Sodium I test, a Potassium test and a Chloride 1 test were conducted. The results were received at FCI McKean on August 24, 2002. The following results were outside of the applicable reference ranges: (1) AST (SGOT) 66 (reference range 11 - 55); (2) Total Bilirubin1 1.60 (reference range 0.20 - 1.30); (3) Globulin 4.0 (reference range 2.0 - 3.7); (4) Gamma GT1 126 (reference range 8 - 78). Id., at p. 131.

sss. On August 26, 2002, he failed to report for a medical callout to have his toenails trimmed. Id., at p. 67.

ttt. On September 5, 2002, he failed to report to have his toenails trimmed. Id., at p. 67.

uuu. On December 6, 2002, he was admitted to the Federal Detention Center (FDC), Milan, Michigan as a holdover inmate. During the medical intake he reported a history of peripheral vascular disease (PVD) in both legs, hypertension, and Hepatitis C. He reported he had his feet repaired due to flat feet. He also reported a history of intravenous drug abuse (heroin), with his last use occurring four years prior. He reported he had a history of syphilis, which was treated in 1996. On examination, his blood pressure was 110 over 80. His legs were edematous with ulcers. He was assessed with PVD in both legs and hepatitis C. He was referred to the Chronic Care Clinic. He was prescribed Pentoxifylline, HCTZ, and encoated aspirin. He was informed of the sick call policy. He was issued a standing restriction and a soft shoe pass. Id., at pp. 64, 150.

vvv. On December 10, 2002, he complained of an ulcer on his left ankle. He requested gauze. He reported a history of PVD and admitted to being a heavy smoker. On observation, his blood pressure was 120 over 80. His pulse was 70 beats per minute. His temperature was 97.8. His weight was 230 pounds. His respiratory rate was 14 times per minute. Examination of his head, eyes, ears, nose and throat were unremarkable. A small ulceration was observed on his left ankle. He was assessed with peripheral vascular insufficiency. He was prescribed Silvadene, and he was issued gauze, and ace bandages. He was told to use moisturizing cream. Id., at p. 65.

www. On December 19, 2002, he was seen at the Hypertension (HTN) Chronic Care Clinic at FDC Milan. His vital signs were unremarkable. He was assessed with hypertension within normal limits. He was told to return to the clinic in three months. His prescriptions for encoated aspirin, Hydrochlorothiazide, and Pentoxifylline were renewed. Id., at pp. 65, 150.

xxx. On March 19, 2003, a complete metabolic reading and a complete blood count were conducted. The results were received at FDC Milan on March 24, 2003, indicating the following results outside of the applicable reference ranges: (1) Glucose 134 (reference range 70 - 110); (2) Total Protein 9.3 (reference range 6.3 - 8.3); (3) Alkaline Phosphate 160 (reference range 49 - 126); (4) AST 95 (reference range 10 - 37); (5) ALT 96 (reference range 8 - 40); (6) Total Bilirubin 1.4 (reference range 0.1 - 1.1); (7) MCV 98 (reference range 81 - 95). Id., at p. 130.

yyy. On or about March 26, 2003, he was admitted to the Federal Transport Center (FTC), Oklahoma City, Oklahoma. On March 28, 2003, it was noted he was prescribed Pentolifylline, Hydrochlorothiazide, and aspirin. Id., at pp. 62, 149.

zzz. On March 31, 2003, his right leg was beginning to have tissue break down, and was very dry. He was assessed with tissue break down on lower legs. The physician was consulted. Id., at p. 62.

aaaa. On March 31, 2003, a medical officer's notation expressed concerns regarding the break down lesions on his right foot. On observation, he was in no apparent distress. No ulcerating lesions were apparent at that time. He was assessed with venous insufficiency of the lower legs. An unna boot was ordered. Id., at p. 62.

bbbb. On April 10, 2003, he indicated he needed a new unna boot, Silvadene and tape. There was no physical examination, because the boot was in place. He was assessed with PVD. A new unna boot was ordered. Id., at p. 63.

cccc. On April 25, 2003, he failed to report for a sick call appointment. Id., at p. 63.

dddd. On or about May 2, 2003, he was received at FCI McKean. All medications were continued until he could be seen in the Chronic Care Clinic. He was given HCTZ, Pentoxifylline, and aspirin. Id., at p. 61. Later on May 2, 2003, I entered an administrative notation into his medical record indicating he had Hepatitis C, and should be placed on the General Medicine II Clinic. His prescriptions for HCTZ, Trental and aspirin were renewed. Id., at pp. 61, 148.

eeee. On May 13, 2003, he was seen in the General Medicine Clinic. He was experiencing problems with the skin of his left ankle. He reported he smoked one cigarette per day, and he watched his diet. He denied experiencing side effects from the medications. His vital signs were unremarkable. He was assessed with Hepatitis C and stasis dermatitis. He was prescribed Hydrochlothriazide, Potassium Chloride (KCl), Trental, encoated aspirin and Silvadene. He was told to return to the HSU each week so his ankle could be wrapped. Id., at pp. 59-60, 148.

ffff. On May 28, 2003, he returned for a re-check of his left ankle ulcer. He stated he was getting better, and he was doing well. On examination, he was in no apparent distress. His blood pressure was 151 over 79. An area on his left ankle appeared to be pre-ulcerous. He was assessed with ulcer. He was told to follow-up as scheduled. He was cleaned an re-bandaged, and educated regarding wound care. Id., at p. 57.

gggg. On May 29, 2003, a liver profile was conducted. The results were received at FCI McKean on June 2, 2003, indicating the following results outside of the applicable reference ranges: (1) AST (SGOT) 57 (reference range 11 - 55); (2) A/G Ratio 0.86 (reference range 1.00 - 2.30); (3) Globulin 4.4 (reference range 2.0 - 3.7); (4) Gamma GT1 106 (reference range 8 - 78). Id., at p. 129.

hhhh. On June 4, 2003, he returned to have his ankle rechecked. He stated he was getting better. On examination, he was in no apparent distress. The area of his left ankle was much improved. He was assessed with ulcer. He was told to follow-up as needed. He area was cleaned and re-bandaged. He was educated regarding wound care. He was given Silvadene cream. Id., at p. 57.

iiii. On July 29, 2003, an administrative notation indicated that during the lunch meal, he advised medical staff he was out of medication for his left ankle ulcer. He was scheduled to see a Physician's Assistant (PA) in the chronic care clinic and with the staff physician the following week. Id., at p. 58.

jjjj. On July 31, 2003, he stated he needed more supplies for his daily dressing changes. He stated he needed gauze and Silvadene. He also complained of overgrown toe nails. On examination two small ulcers were observed on his left

medial ankle. The larger one measured seven millimeters in diameter. His toenails were severely overgrown and discolored and thickened. He was assessed with an ankle ulcer, Onychomycosis (fungal infection that causes fingernails or toenails to thicken, discolor, disfigure, and split), and overgrown nails. His toenails were trimmed with a medical grade clipper. The ankle wound was cleaned with betadine. Wrap-around gauze was applied and secured with tape. He was given supplies, including Silvadene, gauze, tongue depressor and tape. He was told to follow-up as needed at sick call. Id., at p. 58.

kkkk. On August 7, 2003, he failed to report for a sick call appointment. Id., at p. 53.

llll. On August 10, 2003, hef was seen in the General Medicine Clinic II. He complained of bald spots on his scalp and beard. He stated he was cutting down on cigarettes, and was watching his diet. He stated he would start exercising that day. He reported no side effects from medications. On examination, a bald spot measuring one centimeter was seen on top of his head. The medial ankle ulcer was almost healed. He complained of left knee pain. He was assessed with stasis ulcer of the left ankle, PVD, Hepatitis C and seborrhea of the scalp. He was given 4x4 inch gauze and tape. He was prescribed Silvadene, HCTZ, KCl, encoated aspirin, Trental, Betamethasone ointment and Clotrimazole cream. Id., at pp. 55-56, 148.

mmmm. On August 25, 2003, he reported he had enough supplies to last until the following week. At his request, an appointment he had with the nurse was cancelled. Id., at p. 51. Also on August 25, 2003, a liver profile was conducted. On August 27, 2003, the results were returned to FCI McKean, indicating the following results outside of the applicable reference ranges: (1) Alkaline Phosphate 142 (reference range 41-133); (2) AST (SGOT) 77 (reference range 11 - 55); (3) A/G ratio .90 (reference range 1.00 - 2.30); (4) Globulin 4.1 (reference range 2.0 - 3.7); (5) ALT1 67 (SGPT) 67 (reference range 11 - 66)(6) Gamma GT1 129 (reference range 8 - 78). Id., at p. 128.

nnnn. On September 29, 2003, he complained of hair loss for two months. He stated he was losing hair from his face. He reported he was experiencing increased stress and he had Hepatitis C. He was in no apparent distress. Circular patches of hair loss or white hair was noted on his scalp and face. Icteric sclera (yellow appearance of white part of eye) was noted. The remainder of the examination was unremarkable. He was assessed with tinea versicolor (a common, benign, superficial cutaneous fungal infection) and Hepatitis C. He was educated regarding stress management. He was told to follow-up as needed. Blood tests and laboratory tests were ordered. He was prescribed Diflucan (Fluconazole, an antifungal agent) and Selium Sulfide lotion (an anti-infective agent, relieves itching and flaking of the scalp and removes the dry, scaly particles commonly

referred to as dandruff or seborrhea). Id., at pp. 51, 148.

oooo. On October 6, 2003, samples of his blood were collected for a comprehensive metabolic count, an alphafetoprotein count, and a complete blood count. The results returned to FCI McKean showed the following results outside of the applicable reference ranges: (1) Total Protein 8.5 (reference range 6.0 - 8.2); (2) Alkaline Phosphate 142 (reference range 41 - 133); (3) AST (SGOT) 68 (reference range 11 - 55); (4) ALT1 (SGPT) 68 (reference range 11 - 66); (5) Alphafetoprotein 8.8 (reference range 0.0 - 6.0); (6) MCV 99.1 (reference range 82.5 - 96.5); (7) MPV 10.7 (reference range 6.9 - 10.5); (8) Neutrophils 28 (reference range 50 - 70); (9) Lymphocytes 55 (reference range 20 - 40); and (10) Monocytes 14 (reference range 2 - 8). Id., at p. 127.

pppp. On October 8, 2003, an administrative notation was entered into his medical record indicating the laboratory results returned showing he had a slightly elevated liver function including increased MCV (mean cell volume, the average volume of a red blood cell), Lymphocytes, monocytes, and macrocytes. It was also noted he had decreased neutrophils. He was scheduled for an appointment with the PA to check his previous problems. It was recommended that an HIV test and steroids be started if the alopecia did not improve. Id., at pp. 52, 127.

qqqq. On October 13, 2003, he submitted a written request to Dr. Beam complaining he was not being properly treated for Hepatitis C. He also requested dressing supplies. In a response dated October 15, 2003, Dr. Beam advised him the next time he reported to the Chronic Care Clinic, they could talk more about his concerns. If this was time for a liver biopsy and treatment, it would happen. Dr. Beam advised him to report to sick call for dressing supplies for his ankle. Id., at pp. 167-168.

rrrr. In a written request dated October 16, 2003, Cherry requested a liver biopsy. In a response dated October 20, 2003, Dr. Beam advised him they could review his situation at his next Chronic Care Clinic appointment. Id., at p. 169.

ssss. In a separate written request dated October 16, 2003, Cherry requested a Hepatitis A vaccination. In a response dated October 16, 2003, Dr. Beam advised him he would be seen in the Chronic Care Clinic within three weeks. At that time his medical concerns could be discussed. Dr. Beam indicated he would check a blood test for evidence of Hepatitis A infection to see if he needed the vaccine. Id., at p. 170.

tttt. On October 16, 2003, Cherry reported to the HSU to discuss his laboratory tests. It was noted that his hair appeared to be getting better. On examination, he was in no apparent distress, and the examination was unremarkable. He was assessed

with Hepatitis C. An HIV test was ordered. He was educated regarding Hepatitis C and HIV. He was given Silvadene and dressing. It was noted that Dr. Beam would be consulted. He was prescribed Lidex ointment (fluocinide, used for topical therapy of corticosteroid-responsive acute and chronic skin eruptions). Id., at pp. 52, 147.

uuuu. On November 4, 2003, Cherry was seen in the General Medicine Clinic for Hepatitis C and peripheral vascular insufficiency. He stated he was feeling okay, but on some days he felt bad. His right side hurt, and he had headaches. He was quite focused on getting the Hepatitis A vaccine. He stated he probably contracted Hepatitis C in the early 1980s. On examination, it was noted his hair was filling in on his scalp. His blood pressure was 110 over 70. His pulse was 70. His weight was 232 pounds. Examination of his head, eyes, ears, nose and throat was okay. His heart was okay. His lungs were clear, and his abdomen was soft with normal bowel sounds. His laboratory results were recorded. He was assessed with Hepatitis C. He reported he was in no pain. He was educated on etiology, diet, advised to quit smoking, and medication dosage and administration. He was given a Hepatitis A antibody test. He was prescribed Potassium Chloride, HCTZ, Silvadene, Trental, and encoated aspirin. Dressing supplies were given to him. He was given dressing supplies, and he was told to follow-up in the clinic in three months. Id., at pp. 49-50, 147.

vvvv. On November 11, 2003, he reported to sick call complaining his right leg was burning. He indicated the pain was a level seven on a scale of one to ten. He felt burning pain at his right flank, "like fire on the inside" for four days. He stated that during prior episodes, he was hospitalized. He stated his belief this sensation was caused by Hepatitis C. He also complained of hair loss. He requested a refill of Lidex ointment which he believed to be effective. On observation he was in no apparent distress. On his right flank, there were no visible lesions or erythema. When asked, Plaintiff did not point to the right upper quadrant as the site of pain. He was assessed with alopecia and flank pain. He was prescribed Lidex ointment and ibuprofen. He was told to follow up as needed. Id., at pp. 47, 147.

wwww. Results from the November 4, 2003 Hepatitis A antibody test were returned to FCI McKean on November 14, 2003, indicating Cherry tested negative for the Hepatatis A virus. Id., at p. 125.

xxxx. On January 30, 2004, an administrative notation was entered indicating Cherry requested to be re-issued TED hose, because the hose he was previously issued was confiscated. In response, TED Hose was re-issued. Id., at p. 48.

yyyy. On February 4, 2004, he was seen in the General Medicine Clinic for Hepatitis C and peripheral venous disease. He reported he felt well. He reported an abrasion

of the right anterior tibia surface. He stated he had Silvadene, but needed tongue depressors and sponges. A two centimeter abrasion at the anterior right tibia surface was observed. It was noted he self-treated this area with Silvadene and other supplies. Laboratory tests were ordered. He was assessed with Hepatitis C and peripheral vascular disease. He stated he was in no pain. It was noted he watched his diet, exercised, and occasionally used tobacco. He reported no side effects from the medications he was taking. He denied pain. He was prescribed potassium chloride, HCTZ, Silvadene and Trental. He was given the Hepatitis A and B vaccines. He was issued dressing supplies. Id., at pp. 45-46, 147.

zzzz. On March 2, 2004, Cherry was rushed to sick call. He complained the skin of his lower legs was starting to break down. He wanted dressing supplies. He stated he was bleeding the day before. He did not want an unna boot. On examination, he was in no apparent distress. His right anterior tibia showed circular ulcerations of approximately one centimeter in diameter. It was also noted his left medial ankle showed a large area of approximately five centimeters with the beginning of skin degradation. He was assessed with skin ulcers. He was educated to return for his follow-up appointment, and he was advised he would get an unna boot if he did not get better. The area was cleansed with soap and dressed with Silvadene and sterile gauze. An ace wrap was applied and he was given thigh high stockings. He was educated on wound care. Id., at p. 43.

aaaaa. On March 5, 2004, Cherry reported for a follow-up for the skin ulcers on his right lower tibia and left medial ankle. He stated the ulcers were healing. On examination, widespread hyperpigmentation was observed on his lower legs with skin breakdown evident. Two sites measuring one centimeter of ulceration with extremely scant drainage were noted on the dressing at the left medial ankle and the lower right tibia surface. He was assessed with venous insufficiency causing venous ulcers, healing. He was told to continue with daily dressing changes. He was given supplies so he could change the dressing himself. He was given Eucerin and Tylenol. He was given a Commissary pass for March 8, 2004, if he was not qualified to be issued over the counter medication. He was educated regarding wound care and instructed to follow-up at sick call. Id., at pp. 43, 166.

bbbbb. On March 17, 2004, Cherry returned for a re-check of the right leg anterior tibia distal third and left leg at the medial ankle ulcerations. He reported the pain was at a level of four on a scale of one to ten, and there was scant discharge from the ulcerations. On examination, he was in no apparent distress. He wore the TED hose. He ambulated with some affect. Examination of his lower extremities revealed Hyperpigmentation on his legs and feet with pedal edema and breakdown, tender to the touch. Fluid with scant watery discharge was observed on his left medial ankle. His bilateral pulses and temperature were equal. Resolving ulcers were observed at his left ankle and right leg. He was assessed

with peripheral venous disease and stasis ulceration. The dressings were removed and the areas were cleansed. Silvadene with four by four gauze was applied and held in place with Kling, then wrapped with an ace bandage. He was educated on care and use and compliance with medical advice. He was told to continue to wear the TED hose. Wound care supplies were issued. He was told to return as needed. Id., at p. 44.

ccccc. On March 26, 2004, an administrative notation was entered indicating wound care supplies were issued to him by a PA. Id., at p. 44.

ddddd. On March 31, 2004, it was noted that dressing change supplies were issued to him. Id., at p. 44.

eeeee. On April 7, 2004, he was seen for a dressing change and follow-up on the ulcers of his right leg. He denied pain or drainage. On examination, he was in no apparent distress. The right anterior tibia had a large area of venous insufficiency with tissue breakdown. The area was healed without drainage. The tissue remained thin with poor circulation. He was assessed with venous insufficiency and healing ulcer. His dressings were changed. He was educated on skin care and told to follow-up in a week. Id., at p. 41.

fffff. On April 14, 2004, Cherry reported for a dressing change and to pick up dressing supplies. He was in no apparent distress. He was assessed with ulceration healed over with no drainage. His dressings were changed. Silvadene was applied and dry gauze was applied. A one week supply of dressing supplies was issued. Id., at p. 39.

ggggg. On April 14, 2004, an administrative notation indicated Silvadene ointment was prescribed. Id., at pp. 39, 147.

hhhhh. On April 22, 2004, he reported for a re-check of the leg lesion. He stated the ulcers were much improved with no open sores. He was in no apparent distress. On his lower left leg, extensive lesions with scaling, changed pigmentation zones with small papules and larger nodules were observed. He was assessed with venous insufficiency and stasis dermatitis. The areas were cleansed with Betadine. The wounds were redressed with Silvadene, sterile gauze pads, Flexilite sterile gauze, and tape. Seven days worth of cleaning supplies were issued to him for self dressing. He was told to return in one week. It was noted thigh high TED hose were not in stock. He was educated regarding the treatment plan. Id., at p. 39.

iiiii. On April 28, 2004, an administrative notation was entered indicating Cherry reported for a follow-up. The ulceration was clear with no changes. The dressing

was in tact with no drainage. He stated he had enough supplies for dressing changes for the week. Id., at p. 40.

jjjjj. On May 5, 2004, he reported to the General Medicine Clinic. He stated he felt lateral pain at his left lower leg. After an examination, he was assessed with Hepatitis C and PVD. He reported he watched his diet, exercised, and smoked occasionally. He reported no pain. He was prescribed Potassium Chloride, HCTZ and Trental. Id., at pp. 38-39, 147.

kkkkk. On May 20, 2004, he returned for follow-up care for his right leg ulcer and left ankle ulcer. He requested to see the nurse for dressing change supplies. On examination, he was alert and oriented and in no apparent distress. He was ambulatory with affect. His bilateral lower extremity ulcers were healing well with no discharge. He was assessed with venous insufficiency with stasis ulceration. His dressing was changed, and he was issued supplies so he could self-change his dressings. He was prescribed Silvadene ointment, and he was instructed to return as needed. Id., at pp. 36, 147.

lllll. On May 20, 2004, the results of Cherry's liver profile indicated the following levels were outside of the applicable reference ranges: (1) total Protein 8.4 (reference range 6.0-8.2); (2) AST (SGOT) 60 (reference range 11-55); (3) A/G ratio 0.96 (reference range (1.0 - 2.30); (4) Globulin 4.3 (reference range 2.0 - 3.7); (5) Gamma GT1 89 (reference range 8 - 78). Id., at p. 124.

mmmmm. On May 27, 2004, Cherry reported a three day history of redness at his right lower leg which was painful to the touch with no fever. On examination, he looked okay. His right lower leg was slightly red to his mid-calf from the ankle. Chronic stasis changes were observed bilaterally. It was noted he had Tylenol. He was assessed with cellulitis of the right lower leg. He was educated regarding signs of infection, such as increased redness and fever. Ceftriaxone (Rocephin) injections and Keflex were prescribed. Id., at pp. 35, 147.

nnnnn. On May 27, 2004, the first of three injections of Ceftriaxone was given to Cherry per Dr. Beam's instructions to treat cellulitis. Id., at p. 33.

ooooo. On May 28, 2004, An administrative notation was entered indicating the second of three injections of Ceftriaxone was administered. It was noted the procedure was tolerated well without incident. Cherry was told to return the following day for the third and final injection. Id., at p. 33.

ppppp. On May 29, 2004, Cherry returned to receive the third injection of Ceftriaxone to treat the cellulitis. Id., at p. 33.

qqqqq. On June 3, 2004, Cherry returned for a follow-up and for dressing supplies. He stated he was doing well with pain of approximately five on a scale of one to ten. He was in no apparent distress. His right lower leg was warm and hyperpigmented with some erythema and edema. He was assessed with cellulitis. He was educated regarding wound care. Dressing supplies were issued. He was instructed to follow-up as scheduled. He was prescribed acetaminophen and Keflex. Id., at pp. 34, 138.

rrrrr. On June 10, 2004, Cherry returned for a follow-up. He reported he was doing well and had enough supplies. He indicated he had another appointment elsewhere, and requested his health services appointment be rescheduled to the following week. This request was granted, and his appointment was rescheduled. Id., at p. 34.

sssss. On June 17, 2004, an administrative notation was entered indicating dressing supplies were issued to him. Id., at p. 34.

ttttt. On June 24, 2004, Cherry returned to have his leg ulcers rechecked. He reported his toenails were hyperattenuized, long and needed trimming. He reported he was doing very well, and he was mostly healed with and denied tenderness, redness, or discharge. He stated he had enough supplies. He was alert and oriented, and was in no apparent distress. He was ambulatory with affect. His left lower extremity - foot/ankle - was intact and 95% healed with hyperpigmentation, no ulcers or lesions were observed. His bilateral feet, including digits and nails were overgrown with hyperattenuation. He was assessed with PVD, venous insufficiency status post stasis ulcer, and hyperattenuation, elongated, overgrown toenails. He was ordered to continue his medications as prescribed. He was permitted to use HD nail clipper with supervised clipping. The proper nail clipping procedure was completed by Plaintiff without incident. He was instructed to return as scheduled weekly. Id., at p. 31.

uuuuu. On July 1, 2004, an administrative notation indicated Cherry picked up supplies for leg dressing. Id., at p. 32.

vvvvv. On July 8, 2004, an administrative notation was entered indicated Cherry returned to pick up supplies. He reported he was doing well with continued healing and no acute changes. The supplies were issued. Id., at p. 32.

wwwww. On July 15, 2004, Cherry returned for a dressing change and for more dressing supplies. He complained of a laceration to his finger, which occurred the previous night while reaching into his locker, and he was cut by an unguarded razor. On observation he was in no apparent distress. An examination of his lacerated finger near his fingertips showed a laceration approximately five millimeters in length.

Blood crust was in place and hemostasis was noted. No edema or erythema were present. An examination of his lower extremities and feet indicated his skin had irregular texture and color (hyperpigmentation). On his right lateral foot, a superficial one inch skin tear was observed. On his left foot, at least three sites were on the verge of tearing or ulcerating. He was assessed with laceration venous stasis dermatitis/ulcer. He was prescribed Silvadene cream. His finger was cleansed with Betadine and dressed with stick-it and steri-strips were applied. A large band-aid was applied over the steri strips. His feet were irrigated with Betadine, and dressed with Silvadene. Dressing was applied and held in place with flexilite and tape. Plaintiff was educated regarding wound care. He was told to return as needed, and he was scheduled to return in one week. He was issued dressing supplies. Id., at pp. 32, 146.

xxxxx. On July 16, 2004, Cherry reported a medical emergency. He was bleeding profusely from his right ankle lesion. On examination, he was in no apparent distress. The right ankle was covered with the dressing applied on July 15, 2004, and a sock. Both were profusely soaked in blood. After the dressing was removed, the same ulcerated lesion at the lateral aspect that was observed on July 15 was observed. There was no active bleeding at the time of the examination. He was assessed with hemorrhagic episode: ulcerative lesion, venous stasis dermatitis. The area was cleansed with normal saline and one to one normal saline and hydrogen peroxide. A pressure bandage was applied with gauze and flexlite. Supplies were issued for re-dressing as needed. He was given Moban, and an ace bandage. Id., at p. 29.

yyyyy. On July 22, 2004, an administrative notation was entered indicating dressing supplies were issued to Cherry for self dressing changes. He reported he was doing well. He was scheduled to return on July 29, 2004. Id., at p. 29.

zzzzz. On July 29, 2004, Cherry returned for a re-check. He complained of increased pain. He stated Acetaminophen was not working well. He stated he had Motrin but was reluctant to use it because of Hepatitis C. He wanted an unna boot for his right leg and a one week medical convalescence. He stated he had enough acetaminophen, Motrin and Silvadene. On examination, he was in no apparent distress. The skin of his lower extremity had venous stasis dermatitis with irregular discolored skin texture, several superficial, soft, weeping ulcerated lesions greater on his left foot than right foot. He was assessed with venous stasis dermatitis. The areas were cleansed, with one to one hydrogen peroxide and normal saline. Silvadene and an unna boot were applied to his right foot and leg, overlayed with flexilite and an ace bandage. Silvadene, gauze, flexilite and tape were applied to his left foot. He was encouraged to use Motrin as needed for severe pain. He was issued a one week convalescence pass. He was directed to return in seven days. Id., at p. 30.

aaaaaa. On August 3, 2004, Cherry was seen in the General Medicine Clinic. He had the unna boot on his leg and dressing. His Hepatitis C diagnosis was also noted. After an examination, he was assessed with Hepatitis C, and PVD with edema. He stated he was watching his diet; he exercised, an occasionally used tobacco products. His pain level was an eight on a scale of one to ten. His test results and treatment plan were discussed with him. He was educated regarding the etiology, complications, prognosis and prevention of his disease, as well as diet and smoking. He was scheduled to return to the clinic in three months. HCTZ, Potassium Chloride and Trental were prescribed. He was given thigh hip stockings. Id., at pp. 27-28, 146.

bbbbbb. On August 5, 2004, Cherry came to have his legs checked and to have the unna boot re-applied. On examination he was in no apparent distress. The wound area was drier with decreased ulceration. Tenderness and slight edema were noted. He was assessed with venous stasis dermatitis rule out cellulitis. His right leg was cleaned with Betadine. Silvadene and an unna boot was applied to the right foot and leg, then overlayed with flexilite and an ace bandage. He was prescribed Keflex, and he was told to return in seven days. It was noted he was experienced with wound care and his diagnoses. Therefore he was not educated that day. Id., at pp. 25, 146.

cccccc. On August 10, 2004, an HCV quantaSure plus test (measurement of HCV RNA using real-time Polymerase Chain Reaction (PCR) technology) was conducted. The results were returned to FCI McKean on August 16, 2004, indicating the HCV RNA measurement of 3,100,000 International Units (U/L per milliliter). Id., at p. 122. Also on August 10, 2004, a liver profile test was conducted. The results, which were received at FCI McKean on August 12, 2004, indicating the following measurements were outside the applicable reference ranges: (1) Total Protein 9.0 (reference range 6.0-8.2); (2) AST (SGOT) 68 (reference range 11-55); (3) LDH 335 (reference range 354-705); (4) Total Bilirubin1 1.5 (reference range 0.2-1.3); (5) Globulin 4.4 (reference range 2.0-3.7); (6) Gamma GT1 95 (reference range 8-78); (7) Bilirubin Unconj 1.4 (reference range 0.0-1.1); (8) AlphaFetoprotein 6.7 (reference range 0.0-6.0). Id., at p. 123.

dddddd. On August 12, 2004, Cherry reported for a dressing change for his right leg. He had no complaints and no pain. On examination, he was in no apparent distress. The area of his right leg was healing well with no signs or symptoms of infection. He was assessed with stasis ulcer right leg/foot. The area was cleansed with water and hydrogen peroxide. Silvadene and an unna boot were applied. He was educated on skin care and follow-up. Id., at p. 25.

eeeeee. On August 19, 2004, Cherry reported for a dressing change. He had no complaints. He refused to take non-steroidal anti-inflammatories and

acetaminophen for pain because of Hepatitis C despite reassurances. On examination, he was in no apparent distress. The previously ulcerative areas of his right foot were healed. On his left foot, two ulcerative areas were observed. One was at the dorsum at the base of his third and fourth toes. The other was on the lateral aspect of the foot near the arch. He was assessed with venous stasis dermatitis. His feet and right leg were cleansed with one to one normal saline and hydrogen peroxide. Betadine was applied. Silvadene was applied to the ulcerative areas of the left foot and to the formerly ulcerative area of his right foot. The unna boot was applied to the right foot/leg. Gauze dressing was applied to the left foot. Supplies were issued for self-dressing wound care. He was told to return in one week. Id., at p. 26.

ffffff. On August 25, 2004, Cherry returned for a dressing change and for a Hepatitis A and B vaccine. He stated he was doing well and was not in pain. On examination, he was in no apparent distress. His right foot was healed. The skin was waxy and intact. Ulcerative areas were observed on his left foot. He was assessed with vaccines injections and dressing change. He was educated regarding follow-ups. The area was cleansed and bandaged. The unna boot was discontinued. Injections were given without difficulty. He was referred to Commissary for Tylenol. He was issued supplies for dressing changes. Id., at p. 26.

gggggg. On September 2, 2004, an administrative notation was entered into Cherry's medical record indicating he returned for dressing supplies. He reported he was doing well and the healing continued since August 25, 2004. He denied acute changes. He was alert and oriented. He was in no apparent distress. He was ambulatory with affect. He was issued four by four inch gauze pads, Kling, and Silvadene. Id., at p. 23.

hhhhhh. On September 9, 2004, an administrative notation was entered indicating Cherry was issued supplies, and he stated he was doing well with no complaints. Id., at p. 23.

iiiiii. On September 16, 2004, an administrative notation was entered indicating Cherry was issued supplies for dressing changes, and he denied pain. Id., at p. 23.

jjjjjj. On September 23, 2004, an administrative notation was entered indicating Cherry was issued four by four inch gauze pads, Silvadene and Kling. Id., at p. 23.

kkkkkk. On September 30, 2004, an administrative notation was entered indicating Cherry came to pick up supplies. He reported his right lower extremity was doing very well, and his left lower extremity was not responding to standard dressing and may require an unna boot. He was told to return on October 1, 2004 for the unna

boot. Id., at p. 24.

llllll. On October 1, 2004, Cherry reported for a re-check of the stasis ulcers of his left lower extremity. On examination, he was alert and oriented and was in no apparent distress. He was ambulatory with affect. His left lower extremity at his leg, ankle and foot had increased pigmentation, were diffuse and waxy with multiple cutaneous ulcerations. No discharge or redness was observed. However, diffuse tenderness was apparent. He was assessed with PVD and stasis ulceration of the left ankle and foot. The area was cleansed with Hibicleans. Silvadene and the unna boot were applied. He was instructed to return in one week. Id., at p. 24.

mmmmmm. On October 7, 2004, Cherry returned to have the unna boot changed. He stated the stasis ulcer of his left lower extremity was healing. On examination, he was alert and oriented, and was in no apparent distress. He was ambulatory with affect. Two stasis ulcers were observed at his medial malleoulus and lateral malleolus. The ulcer at the medial malleolus as healing, and was 85-95% resolved. The ulcer at the lateral malleolus was healing with minimal changes from October 1, 2004. He was assessed with stasis ulcerations, PVD and peripheral venous insufficiency. The unna boot was reapplied and dressing was applied. He was told to return in one week for a reassessment. Id., at p. 21.

nnnnnn. On October 21, 2004, an administrative notation was entered indicating the stasis ulcers were healing. The unna boot was changed. He was told to return in one week. Id., at p. 22.

oooooo. On October 28, 2004, Cherry was seen in the General Medicine Clinic. He complained of pain in his hip, neck, and back side from sleeping. During the examination, it was noted his left ankle was healing, and some scabbing was evident. He was assessed with Hepatitis C, PVD and edema. He indicated he was experiencing no side effects from the medications. His pain was a seven on a scale of one to ten. He was educated regarding his test results, and his treatment plan was discussed. He was counseled on diet and smoking. He was educated regarding medication dosage and was told to come to sick call as needed. He was told to return in four months. He was prescribed HCTZ, Potassium Chloride, Trental and Tylenol. Id., at pp. 19-20, 146.

pppppp. On November 4, 2004, the ulcers on his lower legs were rechecked. He had no complaints. He was in no apparent distress. The ulcer on his left ankle had healed, and his skin tone was normal. He was assessed with venous stasis ulcer. He was educated to follow-up. The unna boot was applied without difficulty. Id., at p. 17.

qqqqqq. On November 10, 2004, the leg ulcers were re-checked. He stated he was doing

okay. He was in no apparent distress. The skin of his left ankle was in tact without any ulceration. He was assessed with venous stasis ulcer. He was educated to discontinue all treatment, and he was told to follow-up as needed. Id., at p. 17.

rrrrrr. On December 17, 2004, Cherry reported the ulcer of his left leg was breaking down, and he needed an unna boot. On examination, he was in no apparent distress. Ulceration of the left leg at the ankle was observed. He was assessed with stasis ulcer. He was educated regarding wound care. The area was cleansed with Hibicleans. Silvadene was applied, and the unna boot was applied. He was told to return in one week. Id., at p. 18.

ssssss. On December 23, 2004, his left leg was re-checked. He stated he felt okay, but was sore. He stated the pain was a seven on a scale of one to ten. He was in no apparent distress. Improvement was observed with the ulceration of his left ankle. He was assessed with stasis ulcer. He was educated to follow up in one week. The area was cleansed with Hibicleans, and Silvadene and an unna boot were applied. Id., at p. 18.

tttttt. On December 30, 2004, his left foot was re-checked. He stated it was not better. He was in no apparent distress. An area of freshly-healed ulcer with a callous underneath was observed. He was assessed with an ulcer. He was educated to follow up in one week. He was prescribed Bacitracin ointment. Id., at pp. 15, 146.

uuuuuu. On January 6, 2005, his left foot was re-checked. He stated he was doing better. He was in no apparent distress. Improvement was observed of the skin of his left foot. It was in tact with a callus underneath. He was assessed with an ulcer. He was educated regarding use of prescribed medications. He was told to follow-up in one week. Salicylic acid plaster was applied to the area for 48 hours then removed for 24 hours then re-applied. Id., at pp. 15, 146.

vvvvvv. On January 13, 2005, his ulcer was re-checked. He stated the treatment plan was going okay, and his pain had not increased. He was in no apparent distress. Softened tissue under the ulcer of his left ankle was observed. The ulcer remained unchanged. He was assessed with ulcer. He was educated to continue with the wound care. He was told to follow up in one week. A specimen of the irritated skin from his left ankle was taken and sent to an outside laboratory for analysis. The area was cleansed with bacitracin and a bandage was applied. Id., at p. 16.

wwwwww. On January 18, 2005, the results from the skin biopsy from Plaintiff's left ankle was returned to FCI McKean. The specimen was positive for irritated verruca vulgaris (wart). Id., at p. 121.

xxxxxx. On January 19, 2005, he was seen in emergency sick call. He stated his left foot was very painful, at level of ten on a scale of one to ten. He stated the area under the ulcer came off with the acid plaster. He was in no apparent distress. The biopsy results were returned, and they showed verruca vulgaris (common wart). It was noted the area of the skin where the wart came off was in tact but the skin was tender without exudate. He was assessed with an ulcer and verruci. He was educated regarding the treatment plan. He was issued a three day medical idle pass. The area was cleaned. Silvadene and an unna boot were applied. He was rescheduled for unna boot replacement. He was prescribed Motrin. Id., at pp. 13, 146.

yyyyyy. On January 26, 2005, an administrative notation was entered indicating Cherry reported for a dressing change. The ulcer was cleansed with Hibicleans. Silvadene was applied, and dressing was applied. The unna boot was applied and secured with an ace bandage. Healing and granulation were observed. He was told to return on February 2, 2005. Id., at p. 13.

zzzzzz. On January 26, 2005, an administrative notation was entered indicating Cherry requested a refill of Motrin, and it was given to him. Id., at pp. 14, 146.

aaaaaaa. Also on January 26, 2005, a liver profile test was conducted. The results were returned to FCI McKean on February 7, 2005, indicating Cherry's total protein level was high at 8.4 (reference range is 6.0 - 8.2). His LDH level of 340 was low (reference range is 354-705). His A/G ratio of 0.77 was low (reference range is 1.0-2.3). His Globulin level of 4.7 was high (reference range is 2.0-3.7). His Gamma GT1 level of 79 was high (reference range is 8.0- 78). Id., at p. 120.

bbbbbbb. On February 3, 2005, Cherry reported to have his foot checked. He stated the pain was at a level six on a scale of one to ten. He was in no apparent distress. The area of his left foot was healing without problems. Granulation was observed, and there were no signs of infection. Plaintiff was assessed with left foot ulcer. The area was prepped. Silvadene and an unna boot were applied, and secured with an ace wrap. He was educated on care of his leg and foot. He was told to follow up on February 8, 2005. He was prescribed Motrin. Id., at pp. 14, 146.

ccccccc. On February 8, 2005, Cherry had his left foot re-checked. He stated he was doing okay, but was getting a lot of drainage. He was in no apparent distress. Exudate, clear serous fluid, without erythema or edema were observed at his left ankle. He was assessed with an ulcer. He was educated to follow up in one week. The unna boot was applied with ace wraps after it was cleaned with Hibicleans and Silvadene was applied. Id., at p. 11.

ddddddd. On February 9, 2005, Cherry was seen by the contract Optometrist. After an

examination, it was determined Cherry required bifocal eyeglasses. A pair of bifocal eyeglasses was ordered. Id., at p. 159.

eeeeeee. On February 9, 2005, an administrative notation was entered indicating Cherry's prescription for Motrin was renewed. Id., at pp. 11, 146.

fffffff. On February 22, 2005, Cherry had his left ankle re-checked. He stated he was doing well. On examination, he was in no apparent distress. The skin of his left ankle was waxy, without exudate or erythema. Mild edema was observed. He was assessed with stasis ulcer. He was educated to continue with the unna boot. The area was cleansed with Hibicleans. Silvadene and the unna boot were applied. He was told to follow-up in one week. Id., at p. 12.

ggggggg. Also on February 22, 2005, Cherry was seen in the General Medicine Clinic. It was noted he was being treated by a PA for venous stasis and left ankle skin breakdown. He was assessed with Hepatitis C, PVD, and venous stasis. His test results and treatment plan were discussed with him. He was educated regarding diet and smoking, He was told to return to the clinic in three months. He was prescribed HCTZ, Potassium Chloride, Trental, Tylenol, and Bacitracin. He was told to continue to visit the HSU for weekly dressing changes. Id., at pp. 9-10, 145.

hhhhhhh. On March 11, 2005, Cherry was brought to the HSU to have his ankle ulcer checked. He stated he took his unna boot off after ten days, and he was not experiencing pain. On examination, he was in no apparent distress. The skin of his left ankle was in tact and thin. The band of verruca vulgaris was still present. His right ankle had a similar band of growth. He was assessed with venous stasis and verruci. He was educated regarding a treatment plan. He was told to follow up as needed. The area of both ankles with growths was treated with Podophyllin (a resin used to treat warts), and covered with a band-aid. He was instructed to leave the medication on for 24 hours. Id., at p. 7.

iiiiiii. On March 18, 2005, an administrative notation was entered into Cherry's record indicating that during an institutional lock-down sick call visit, he was prescribed Bacitracin. Id., at pp. 8, 145.

jjjjjjj. On April 1, 2005, a Hepatitis C virus genotyping test was conducted. Id., at p. 118. The results from this test were returned to FCI McKean on April 11, 2005, indicating Plaintiff had type Ib Hepatitis C. Id., at pp. 7, 118.

kkkkkkk. Also on April 1, 2005, a hepatic function Panel, BUN Creatinine, and serum tests were conducted. The results were within normal limits, except for the hepatic function panel, which indicated Cherry was high for AST (SGOT), which was 63

(average range is 0-40), and ALT (SGPT), which was 59 (average range is 0-40). Id., at p. 119.

lllllll. On April 5, 2005, Cherry reported for a re-check of his ulcer and stated he was doing great. He was in no apparent distress. An area of rough skin was noted at his heel. He was assessed with verruci. He was instructed to follow up every Tuesday. Podophyllin was applied to his heel. Id., at p. 8.

mmmmmm. On April 11, 2005, an administrative notation was entered into Cherry's medical records indicating his test showed he had type Ib Hepatitis C. It was indicated this would be followed up at the clinic. Id., at p. 7.

nnnnnnn. On April 15, 2005, Cherry had his feet re-checked. He stated he was doing okay. He was in no apparent distress. It was noted the rough areas of his foot had improved. He was assessed with verruci. He was educated to follow-up every Tuesday. Podophyllin was applied to his left heel. Id., at p. 8.

ooooooo. On April 28, 2005, Cherry had his ankle re-checked. He stated it hurt sometimes. He was in no apparent distress. It was noted that the areas of his heels where the Podophyllin was applied appeared to be white from the treatment. He was assessed with venous stasis with verruci. He was educated to follow up in one week. Podophyllin was applied to his ankles bi-laterally without difficulty. Id., at p. 6.

ppppppp. On May 3, 2005, Cherry had his ankle re-checked. He stated he felt severe pain and swelling of his ankles bilaterally. He stated the pain was a ten on a scale of one to ten. The area of verruci was white and peeling. No exudate, no erythema or edema were observed. He was assessed with verruci. He was educated regarding the treatment plan. He was told to follow up in one week. The area was debrided bilaterally and cleansed with Hibicleans and Providine. Silvadene was applied, and the unna boot was applied. He was placed on a medical idle until May 6, 2005. Id., at p. 6.

qqqqqqq. On May 10, 2005, Cherry was seen in the General Medicine Clinic. He stated, "I need to be in a wheelchair." He also stated he was due for an unna boot change the following day. He stated the pain was terrible. He wanted Motrin, and indicated the risks with Hepatitis C. He had an upper respiratory infection, with a cough and yellow phlegm. The physician noted that at the sick call appointment scheduled for the following day, he would check the unna boot, warts and Silvadene issues. He was assessed with PVD, Hepatitis C, and Bronchitis. It was noted his pain was a nine on a scale of one to ten. He was issued a medical idle for 2-3 weeks and instructed to elevate his lower extremities. He was told to return to the clinic in three months. He was prescribed Motrin, Bacitracin,

Silvadene, HCTZ, Potassium Chloride, and Trental. Id., at pp. 5, 145.

rrrrrrr. On May 11, 2005, Cherry had his ankle ulcers checked. He stated he was in a lot of pain, but it was better. He was in no apparent distress. Crusted areas were noted on his ankle bilaterally. No exudate, edema or erythema were observed. He was assessed with verruci. He was educated to follow up in two days. Unna boots were removed, and his ankles were cleansed with hibicleans. Id., at p. 2.

sssssss. On May 13, 2005, Cherry's ankles were re-checked. He complained of pain at a level of nine on a scale of one to ten. It was noted he went against the Physician's Assistant's advice by applying Silvadene and bandages to the area. He was in no apparent distress. Increased ulceration of the ankles bilaterally were observed. He was assessed with ulcers. He was educated to follow up in a week. The unna boots were applied with Adaptec and Silvadene. Id., at p. 2.

ttttttt. On May 27, 2005, an administrative notation was entered indicating Cherry came to the HSU for medical supplies. He was given gauze squares, and Silvadene ointment. Id., at p. 3.

uuuuuuu. On June 10, 2005, Cherry's ankles were re-checked. He stated his right ankle was completely healed, and he was doing great. He stated his left ankle had some pain, and was at a pain level of five on a scale of one to ten. He stated he was doing much better overall. He was in no apparent distress. The skin of his right ankle was in tact with no pain upon palpation. The skin of his left ankle was in tact and waxy with some pain upon palpation. He was assessed with stasis ulcers resolving. He was educated regarding leg care. The unna boot was applied with Silvadene to his left ankle/leg. He was told to follow-up in one week for a boot-off toenail trim. He was prescribed Bacitracin ointment. Id., at pp. 3, 145.

vvvvvvv. On June 17, 2005, Cherry had the stasis ulcer of his right foot re-checked. Thick overgrown toenails in need of trimming were observed. His right foot appeared to be healing and was looking good with no secondary infection. He was assessed with stasis ulcer resolving, left foot and Onychomyosis (a fungal infection of the toenails) of both feet. The unna boot was applied and secured with an ace bandage. His toenails were trimmed. He was told to return in one week. Id., at p. 1.

4. Attached hereto, please find a true and correct copy of the prison medical record of inmate Darryl Lee Cherry, Reg. No. 07928-078.

Pursuant to the provisions of 28 U.S.C. §1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this 6 day of September, 2005.

Dennis Olson, MD

Dennis Olson, M.D.
Clinical Director
Federal Bureau of Prisons
Federal Correctional Institution
McKean County, Pennsylvania